The prevention of suicide in later life: a task for GPs?

Suicide is a relatively uncommon event. In England about 5000 people of all ages take their own lives each year. In the 4 years between 1996 and 2000, the deaths of 20 927 people from suicide, undetermined causes or where there were open verdicts were reported to the National Confidential Inquiry for England and Wales.[1]

However, suicide rates among older people — particularly men — are rising worldwide.[2] In the UK about one in every eight people who commit suicide is aged 65 years or over. Men aged over 75 years have the highest rate of suicide of any age group, a trend reflected in the study of suicidal ideas among older people seen by Australian GPs, reported in this issue of the Journal.[3]

In England and Wales 1126 men and 628 women in the age group 65–74 years committed suicide, as did 1178 men and 736 women aged 75 and over. Although older women are more likely than men to experience severe depression, men are more likely to commit suicide. Among older people 80% committed suicide on what was apparently their first attempt.

If we can understand why people kill themselves we may be able to help them avoid suicide as a solution to their problems. In the present policy climate this logic leads to the publication of strategies to prevent suicide, with implementation groups addressing problems at local levels.[4–6] Early indications from England are that this strategic approach is having an effect and the suicide trend is now downward. This seems to have been accomplished by addressing issues broadly and thorough multiagency collaboration, by conducting audits and identifying areas where there are major knowledge gaps, and by lowering risks, notably through reducing access to means of suicide.[7]

Most older people who commit suicide have had recent contact with their GP (about one-third in the preceding week), although a large minority have had no contact with any services. Most also had symptoms of major depression, although some had no signs of any psychological problems. There is always the temptation to note the frequent contact between older people who commit suicide and their GPs, and assume that GPs are therefore well placed to identify those depressed people at risk of self-harm, to intervene and to avert suicide. However, Pfaff and Olmeida[3] point out that there was nothing specific in the presentations of older people to alert the GP to the presence of suicidal ideas, a finding that must make us think more carefully about the origins and causes of suicide in later life.

In a review of the limited epidemiological literature on suicide in later life, O'Connell and colleagues[8] caution against a reductionist approach to a complex topic. This is a wise warning, because suicide in later life has an unclear cause, a low incidence but a high social impact, sending ripples of distress, sorrow and guilt through families, professionals, communities and institutions. Moreover, the epidemiological perspective itself makes older people who commit suicide into objects of disease processes (mainly depression) rather than subjects struggling to retain control of their own lives, and so gives us limited insights.

A 'psychiatric autopsy' approach can be helpful here. Snowden's review of coroners' records of 210 older people who committed suicide[9] showed that a quarter had 'understandable' reasons for doing so, because they wanted to end physical suffering or relieve a perceived burden on others. One in eight were in situations that they experienced as untenable (financial ruin, or guilt) and a third were depressed in response to loss, including bereavement or worsening of their health and capabilities. Under a third had dementia, depression unrelated to an obvious external event or experience, or another psychiatric diagnosis.

Chronic and painful illness or disability, alcohol misuse, or abuse of sedatives and hypnotic drugs seem to be factors that explain suicide in some older people. Physical illness seems to be more important as a trigger for suicide in older men than in women,[10] and poor pain control seems particularly significant.[11] Studies of attempted suicide such as that of Hepple and Quinton, who followed up 100 cases,[12] suggest that older people who attempt suicide have a high mortality rate from later completed suicide and from other causes. Even many years after an attempt, the risks remain heightened, as a study of outcomes in the two decades after suicide attempts illustrated.[13]

Much seems to depend on the meaning of problems for individuals, which may explain why suicide is more common in older men, while depression is more prevalent among older women. Proud but rather rigid individuals who would rather not live if unable to do so with their normal vigour may opt for suicide, especially if depressed mood alters their assessment of the implications of their illness or disability. Older men living alone, whose lives are changed for the worse by loss, illness or disability, may be the highest risk group, but they may be also those least likely to engage with services.[14]

Even if individuals at risk can be identified, what therapies are available? Studies of what seems effective in averting suicide are less common than those analysing its causes, but interviews with people about what helps when they feel suicidal found that they considered a variety of contacts supportive.[15] These include access to psychiatric services, their relationship with social and religious networks and self-help groups. They felt that the stigma of mental illness made their problems worse, which is significant for GPs since we know that disclosing emotional problems in a primary care consultation is often experienced as stigmatising, even if suicide is not being considered.[16] Reducing the stigma of mental health problems is easier said than done, of course, and work is largely focused on young people.[17]

This may help explain the limited

evidence of interventions to support older people and those working with them. In an important study from Sweden, Rutz and colleagues evaluated a community-wide approach to prevention of suicide through an intervention directed at GPs.[18] All GPs on the island of Gotland received education about suicide risks and depression in later life. Following this, suicide rates on the island were found to have declined when compared to the rest of Sweden (they had been the same for the previous 17 years). While this study has proved difficult to replicate, and may not be conclusive, it suggests that such education and training can be effective. From Italy comes an example of a longer-term support service for older people, who were provided with a telephone helpline and advice line.[19] The number of suicides, especially among older women, decreased over an 11-year period. Few such interventions are available for consideration by practitioners and commissioners.

This is surely a matter of concern, for the impact of suicide on those who are involved either personally or professionally is often immense and may be long-lasting. Family members and friends left behind after a suicide face a heavy burden,[20] for while bereavement by suicide is not necessarily more severe than other types, stigmatisation, shame and a sense of rejection are more common.[21] The ripples of the event can provoke feelings of blame and guilt, with practitioners moving away from work in this area or finding that their judgement is impaired. Colleagues can be supportive but they may prove insensitive and suggest that practice has been inadequate and that the individual worker is at fault. 'Postvention', stopping the ripples becoming overwhelming, can help those facing bereavement by suicide, and counselling for individuals, families or groups may be effective, although there is not yet much conclusive evidence.[21] For families, voluntary sector self-help groups may be particularly helpful because of the continued stigma of suicide and its effect on those who are linked to it by association. The UK is fortunate in having a number who are helping with the implementation of its suicide strategies as well as providing support for individuals (such as SOBS [Survivors of Bereavement by Suicide] www.uk-sobs.org.uk and CRUSE [www.crusebereavementcare.org.uk]).

Pfaff and Olmeida[3] have demonstrated that some older people attending general practice clinics have suicidal thoughts, but do not imply that they have suicidal intent, or that their thoughts indicate a high probability of self-harm. While all of us could usefully fine tune our skills in recognising and responding to the hopelessness that makes suicide acceptable to some older people, we do need to understand our limitations. Coping strategies built over a lifetime can collapse under the impact of successive adverse events, and our ability to influence either coping strategies or adverse events may be more limited than we would like. A perceived failure to prevent suicide can have adverse effects on practitioners, so policies for identifying those at risk need to be realistic.

Vigorous screening of older people, advocated by O'Connell and colleagues,[8] is therefore not an acceptable or realistic task for GPs, and would not marry well with the broader strategies referred to above. General practice may focus its attention better on optimal management of disabilities, improving pain control and achieving greater financial security for vulnerable older people. These seem options worth pursuing, with antidepressant medication and psychological therapy on offer to those with depression symptoms. Peer support programmes and responses to those affected by suicide could also be added to the list of tasks. Critical incident reviews of suicide in older patients may highlight ways in which prevention, intervention and postvention can be improved.

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